Pediatric History Form

Initially completed on: _____ **updated:** _____ _____ _____ _____ _____ _____

Demographics

Child's Name: _____ **Date of Birth:** _____ **PCM:** ☐ PNP Hallock ☐ Dr. Parker

Address: _____ **Email:** _____

Contact phone 1st choice: _____ ☐ **Mom's** ☐ **Dad's** ☐ **Work/cell/home?**

Contact phone 2nd choice: _____ ☐ **Mom's** ☐ **Dad's** ☐ **Work/cell/home?**

Pregnancy and Birth

What gestational age was your child? ☐ **Term (37-42 weeks)** ☐ **Other:** _____

What was the method of delivery? ☐ **Spontaneous vaginal** ☐ **Forceps** ☐ **Vacuum-assisted** ☐ **Cesarean section** ☐ **Breech**

☐ **Other, explain:** _____

What was your child's birth weight? _____**Pounds** _____**Ounces** **What was your child's birth length?** _____**Inches**

Please check any of the following that were present during the pregnancy, delivery, or early newborn period?

- ☐ Mother used medications
- ☐ Mother used tobacco during pregnancy
- ☐ Mother drank alcohol
- ☐ Maternal infection (i.e. HIV, CMV, herpes rubella, gonorrhea, chlamydia, or syphilis)
- ☐ Maternal medical condition (i.e. diabetes, pre-eclampsia, high blood pressure depression, thyroid problem)
- ☐ GBS (Group B Strep) positive
- ☐ Blood type incompatibility
- ☐ Abnormal ultrasound or quad screen
- ☐ Too much or too little amniotic fluid
- ☐ Breech position
- ☐ Emergency delivery
- ☐ Low APGAR score(s)
- ☐ Birth defects or abnormal exam
- ☐ Spent time in the NICU
- ☐ Mom had fever or infection during labor.
- ☐ Jaundice
- ☐ Too much weight loss
- ☐ Problems urinating
- ☐ First stool after day 2
- ☐ Did not pass hearing or genetic screen
- ☐ Other: _____

_____

_____

Past Medical History

Please list any overnight hospital stays that your child has had including diagnosis/condition, general dates, and locations:

_____ _____

_____ _____

Please list any surgeries your child has had including dates and locations:

_____ _____

_____ _____

Home Life

Who lives at home with the child? ☐ Mom ☐ Dad ☐ # of Brothers_____ ☐ # of Sisters_____ ☐ Other: _____

Are there other siblings not living at home? ☐ Yes ☐ No If yes, please list number and age(s): _____

What best describes the relationship between the biological parents? ☐ Married ☐ Other: _____

If one or both biological parents do not live at child's home, how often does the child see the parent not living at home?

Mom: _____ Dad: _____

Please complete both sides

Patient and Family Medical History

A thorough understanding of your child's and family's medical history is essential to taking proper care of them. Please answer whether the patient or anyone else in the family has any of these listed conditions. Please explain any necessary specifics at bottom of the page.

Condition	Patient	Patient's Father	Patient's Mother	Patient's Sibling(s)	Father's Parent(s)	Mother's Parent(s)	Other
Epilepsy or seizures	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐
Neural tube defect (i.e. spina bifida)	☐	☐	☐	☐	☐	☐	☐
Developmental delay	☐	☐	☐	☐	☐	☐	☐
Learning disability, mental retardation, or autism	☐	☐	☐	☐	☐	☐	☐
ADHD or ADD	☐	☐	☐	☐	☐	☐	☐
Mental illness (i.e. depression, bipolar, anxiety, schizophrenia)	☐	☐	☐	☐	☐	☐	☐
Heart defects, rhythm problems, enlarged heart, or cardiomyopathy, long or short QT syndrome, Brugada syndrome, tachycardia (fast heart rate), pacemaker or defibrillator implanted, or illness involving the heart	☐	☐	☐	☐	☐	☐	☐
Sudden unexplained death, fainting, or near drowning.	☐	☐	☐	☐	☐	☐	☐
Cystic fibrosis	☐	☐	☐	☐	☐	☐	☐
Asthma or reactive airway disease	☐	☐	☐	☐	☐	☐	☐
Inflammatory bowel disease, celiac disease, or colon polyps	☐	☐	☐	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	☐	☐	☐
Frequent abdominal pain	☐	☐	☐	☐	☐	☐	☐
Jaundice or liver disease	☐	☐	☐	☐	☐	☐	☐
Kidney disease (i.e. polycystic kidneys or nephrotic syndrome)	☐	☐	☐	☐	☐	☐	☐
Recurrent urinary tract infections	☐	☐	☐	☐	☐	☐	☐
Clotting disorder (i.e. hemophilia, easy bleeding, blood clots, or pulmonary emboli)	☐	☐	☐	☐	☐	☐	☐
Anemia (i.e. sickle cell disease, spherocytosis, or thalassemia)	☐	☐	☐	☐	☐	☐	☐
Endocrine disease (i.e. thyroid disorder or diabetes type 1)	☐	☐	☐	☐	☐	☐	☐
Autoimmune disease (i.e. multiple sclerosis, lupus, or rheumatoid arthritis)	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Eczema or other chronic recurrent skin problems	☐	☐	☐	☐	☐	☐	☐
Environmental allergies (i.e. hay fever)	☐	☐	☐	☐	☐	☐	☐
Food allergies	☐	☐	☐	☐	☐	☐	☐
Frequent ear infections or hearing conditions	☐	☐	☐	☐	☐	☐	☐
High blood pressure, high cholesterol, or diabetes type 2	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐
Snoring or sleep conditions	☐	☐	☐	☐	☐	☐	☐
Coronary artery disease, heart attack, or stroke before age 55 (males) or 65 (females)	☐	☐	☐	☐	☐	☐	☐
Conditions involving eyes or vision	☐	☐	☐	☐	☐	☐	☐
Miscarriage, still births, or SIDS	☐	☐	☐	☐	☐	☐	☐
Drug/alcohol abuse	☐	☐	☐	☐	☐	☐	☐
Genetic disorders (i.e. Neurofibromatosis, Huntington disease, 22q11, DiGeorge, Marfan, glycogen storage disease, Fragile X, or PKU)	☐	☐	☐	☐	☐	☐	☐
Other or additional family health history not listed above:							
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Explain any specifics here: